		& MEDICAID SERVICES	454	, ,	<u>3 NO. 0938-0391</u>
TEMENT OF DEFICIENCIES) PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
		445314	B. WING		03/05/2014
ME OF PROVIDER OR SUPPLIER FE CARE CENTER OF MORRISTOWN			5	STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD MORRISTOWN, TN 37814	
X4) ID 'REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 272 SS=D	a comprehensive, a	PREHENSIVE Induct initially and periodically accurate, standardized ament of each resident's	F 272	Corrective Action: For resident #122 the MDS was corrected on 3/13/14 to reflect resident #122's missing and decayed teeth by MDS Coordinator.	3/13/14
	A facility must make assessment of a res resident assessment by the State. The all least the following: Identification and de Customary routine; Cognitive patterns; Communication;	e a comprehensive sident's needs, using the sident's needs, using the strument (RAI) specified assessment must include at emographic information;		Residents with Potential to be Affected: All residents have the potential to be affected. A 100% audit of all current residents Dental Status are compared to their MDS to assure accurate coding and completion of the MDS completed by 3/19/14 by DON, ADON, and other Nursin Administration.	3/19/14 ng
	Continence; Disease diagnosis a Dental and nutritiona Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of su the additional assess areas triggered by th Data Set (MDS); and	cial well-being; unctioning and structural problems; e; iagnosis and health conditions; d nutritional status; dions; rsuit; as; eatments and procedures; potential; ation of summary information regarding and assessment performed on the care ered by the completion of the Minimum		Systematic Changes: Review and Education was provided to M Coordinators on proper and accurate cod by DON on 3/13/14, MDS Coordinator educated to assess residents dental statu and review the oral assessment when completion of the oral section of the MDS	ling s
ATORY D		VSUPPLIER REPRESENTATIVE'S SIGNA		50 3/19/14	(X6) DATE

afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ig the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued n participation.

EPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES & MEDICAID SERVICES			O		APPROVED 0938-0391
TATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		445314	B. WING	;_		03/	05/2014
NAME OF	PROVIDER OR SUPPLIER	-		Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
IFE CA	ARE CENTER OF MOR	RISTOWN			501 WEST ECONOMY ROAD MORRISTOWN, TN 37814		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	by: Based on medical and interview, the fa assess dental statu twenty-nine residen The findings include Resident #122 was October 16, 2013, was Alzheimer's Disease Anxiety Disorder, and Review of an Admis (MDS) dated October sident was severed did not have any mis Observation of the register of the re	T is not met as evidenced record review, observation, ecility failed to accurately s for one resident (#122) of ts reviewed.	F	272	Monitoring: A Performance Improvement Plan was initiated on 3/5/14 addressing education audit and monitoring of Dental Assessm for MDS being completed appropriately all residents. DON, ED, Medical Director ADON, other Nursing Administration are other facility Department Managers reviewed the Performance Improvement Meeting on 3/14/14. An will be completed weekly on all new admissions' MDS's for six weeks by DOI ADON and other Nursing Administration ensure accurate MDS dental assessment with a completion date of 4/24/14. The MDS dental assessments will then be audited by DON, ADON, and other Nursing Administration randomly and as needed.	nents y on r, nd nt audit N, n to nts	3/5/14
F 309 SS=D	and Registered Nurs at 9:58 a.m., in the Country the resident had multiple management data inaccurate. 483.25 PROVIDE CAN HIGHEST WELL BE Each resident must reprovide the necessar	eceive and the facility must y care and services to attain	F3	09	Corrective Action: For resident #117 foot rests were immediately applied to residents Broda chair on 3/3/14 by RN unit Manager. Education was immediately completed 1	oy .	3/3/14
- 1	mental, and psychos	est practicable physical, ocial well-being, in comprehensive assessment	·		RN unit Manager to staff caring for resident #117 on the necessity for foot rests to be applied to Broda chair.	lent	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		& MEDICAID SERVICES			^		APPROVED
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT	. 0938-0391 TE SURVEY MPLETED
		445314	B, WING	;_	·	02	/05/201 4
NAME OF	PROVIDER OR SUPPLIER		<u>.i</u> .	s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03	105/2014
				ı	01 WEST ECONOMY ROAD		
LIFE CARE CENTER OF MORRISTOWN				l l	MORRISTOWN, TN 37814		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE	(XS) COMPLETION DATE
F 309	Continued From pagand plan of care.	ge 2	F	309	All residents have the potential to be affected. A 100% audit of all residents	was	3/17/14
	This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain proper body positioning for one resident (#117) of twenty-nine residents reviewed.				completed on 3/17/14 by DON, ADON, DOR, Therapy Staff, and other Nursing Admin to ensure residents have proper positioning devices in place with their wheelchairs. A 100% audit was comple on 3/17/14 by DON, ADON, and other	r	
	The findings included: Resident #117 was admitted to the facility on March 1, 2012, with diagnoses including Alzheimer's Disease, Unspecified Psychosis, Abdominal Aortic Aneurysm, and Gastric Reflux. Review of the Quarterly Minimum Data Set (MDS) dated November 29, 2013, revealed the resident was severely cognitively impaired, dependent for transfers, and at risk for the				Nursing Administration to compare residents positioning devices to the list of ordered positioning devices from our pharmacy. A 100% audit was complete 3/17/14 by DON, ADON, and other Nur Administration to ensure all positioning devices listed on care plans, care direct and physician orders match what is physically in place for residents.	r d on rsing	
	Observation of the refrom 11:24 a.m. to 12 resident seated in the chair (a specialty chabody position for dep Continued observation lower legs and feet woff the end of the chair (should be brode chair's legs with the resident's legs on tinued observation egs were lying against supports and no pado	sure ulcers. esident on March 3, 2014, 2:15 p.m., revealed the e resident's room, in a broda iir that is used to maintain			Systematic Changes: Review and Education was completed wall staff on 3/14/14 by Director of Rehalm and Physical Therapy about positioning devices procedures. As of 3/5/14 any norder for positioning devices will be reviewed daily during clinical meeting worden by DON, ED, ADON, and Nursing Administration to ensure they are placed care directives, physician orders and capplans.	b sew with	3/14/14

DEPARTMENT OF REALTH AND HUMAN SERVICES

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE PROPERTY OF THE APPROPRIATE DATE OF THE OF THE OF			AND HUMAN SERVICES				FORM	APPROVED
AME OF PROVIDER OR SUPPLIER IFE CARE CENTER OF MORRISTOWN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR TAG COntinued From page 3 revealed the chair did not have a foot rest attached. Continued observation revealed the resident's lower extremities were slightly edematous (skwollen) at the ankles. Continued observation revealed the resident could not reposition the lower extremities independently in the chair. Observation on March 3, 2014, from 12:15 p.m. to 12:20 p.m., revealed a facility staff member transported the resident to the dining area in the broad a chair, and did not attempt to reposition the resident's legs. Observation of the resident in the East Wing Dining Area on March 3, 2014, from 12:20 to 12:25 p.m., revealed the resident seated in the broad a chair, and did not attempt to reposition at the production of the resident seated in the broad a chair in the same position as previously observed, being assisted by a staff member with	ATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		E CONSTRUCTION	(X3) DAT	E SURVEY
IFE CARE CENTER OF MORRISTOWN SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG COMPLETED TAG CONTINUED FROM THE PROPORTIES TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 3 revealed the chair did not have a foot rest attached. Continued observation revealed the resident's lower extremities were slightly edematous (swollen) at the ankles. Continued observation revealed the resident was severely cognitively impaired, was unable to follow commands, and spoke in garbled sentences. Continued observation revealed the resident could not reposition the lower extremities independently in the chair. Observation on March 3, 2014, from 12:15 p.m. to 12:20 p.m., revealed a facility staff member transported the resident to the dining area in the broad achair, and did not attempt to reposition the resident's legs. Observation of the resident in the East Wing Dining Area on March 3, 2014, from 12:20 to 12:25 p.m., revealed the resident seated in the broad chair in the same position as previously observed, being assisted by a staff member with		·	445314	B. WING	·		03/	05/2014
F 309 Continued From page 3 revealed the chair did not have a foot rest attached. Continued observation revealed the resident's lower extremities were slightly edematous (swollen) at the ankles. Continued observation revealed the resident could not reposition the lower extremities independently in the chair. Observation on March 3, 2014, from 12:15 p.m. to 12:20 p.m., revealed a facility staff member transported the resident to the dining area in the broda chair, and did not attempt to reposition the resident's legs. Observation of the resident in the East Wing Dining Area on March 3, 2014, from 12:20 to 12:25 p.m., revealed the resident seated in the broda chair in the same position as previously observed, being assisted by a staff member with	IFE CARE CENTER OF MORRISTOWN				5	01 WEST ECONOMY ROAD		
revealed the chair did not have a foot rest attached. Continued observation revealed the resident's lower extremities were slightly edematous (swollen) at the ankles. Continued observation revealed the resident was severely cognitively impaired, was unable to follow commands, and spoke in garbled sentences. Continued observation revealed the resident could not reposition the lower extremities independently in the chair. Observation on March 3, 2014, from 12:15 p.m. to 12:20 p.m., revealed a facility staff member transported the resident to the dining area in the broda chair, and did not attempt to reposition the resident's legs. Observation of the resident in the East Wing Dining Area on March 3, 2014, from 12:20 to 12:25 p.m., revealed the resident seated in the broda chair in the same position as previously observed, being assisted by a staff member with	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULT CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
Observation with Registered Nurse #2 (RN #2) who was the unit manager, on March 3, 2014, at 12:26 p.m., in the dining area, revealed the posterior surface of the resident's calves bilaterally exhibited red marks identical in size and shape to the straps of the chair. Interview with RN #2 on March 3, 2014, at 12:27 p.m., in the dining area, confirmed the chair was to have a footrest attached, the resident's legs and feet were not properly supported in the chair, and the facility failed to maintain proper body positioning of the dependent resident. F 371 483.35(i) FOOD PROCURE,		revealed the chair of attached. Continued resident's lower extredematous (swoller observation reveale cognitively impaired commands, and spectontinued observation independently in the Observation on Marto 12:20 p.m., reveatransported the resident's legs. Observation of the rediction of the different observation with Rediction of the different observation of the dependent of the rediction of the r	lid not have a foot rest dobservation revealed the remities were slightly at the ankles. Continued the resident was severely, was unable to follow oke in garbled sentences. Ion revealed the resident the lower extremities e chair. ch 3, 2014, from 12:15 p.m. led a facility staff member dent to the dining area in the not attempt to reposition the resident in the East Wing ch 3, 2014, from 12:20 to do the resident seated in the ime position as previously isted by a staff member with gistered Nurse #2 (RN #2) mager, on March 3, 2014, at ning area, revealed the the resident's calves ed marks identical in size aps of the chair. on March 3, 2014, at 12:27 ea, confirmed the chair was ached, the resident's legs operly supported in the chair, to maintain proper body pendent resident.			A 100% audit will be completed daily two weeks to ensure all ordered positions devices are in place for residents by D ADON, and other Nursing Administrat with completion date of 3/19/14. A 1 audit will be completed weekly for a reto ensure all ordered positioning deviare in place for residents by DON, AD and other Nursing Administration wit completion date of 4/1/14, and then will be audited randomly and as need Performance Improvement Plan was initiated 3/5/14 to address procedure position devices and reviewed during facility Performance Improvement me on 3/14/14 with attendance by ED, Do ADON, Medical Director, Nursing Administration, and other Department	tioning OON, tion OO% month ces ON, h they ed. A e for eeting ON,	3/5/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FINITIED, USTRUIZU14 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 445314 B. WING 03/05/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 501 WEST ECONOMY ROAD LIFE CARE CENTER OF MORRISTOWN MORRISTOWN, TN 37814 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Corrective Action: F 371 | Continued From page 4 3/3/14 F 371 Jar of pimento cheese was immediately SS=F STORE/PREPARE/SERVE - SANITARY discarded by Dietary Manager on 3/3/14. Residents with Potential to be Affected: 3/3/14 The facility must -All residents have the potential to be (1) Procure food from sources approved or affected. A 100% audit of all food items in considered satisfactory by Federal, State or local refrigerator, freezer, and dry storage was authorities: and (2) Store, prepare, distribute and serve food completed by Dietary Manager on 3/3/14 under sanitary conditions to ensure all food was stored under sanitary conditions. Systematic Changes: 3/12/14 Review and Education completed with all dietary staff on 3/12/14 by Dietary Manager This REQUIREMENT is not met as evidenced on Policies and procedures for storing food by: Based on observation and interview, the facility under sanitary condition. All food must failed to ensure outdated foods were not available have label with name of product, date for residents, and failed to ensure dirty food carts made or brought out of freezer and use by were not stored in clean areas of the kitchen. date. All items must not be used later than the use by date. If food item is past use by The findings included: date it must be disposed of immediately

Observation on March 3, 2014, at 9:15 a.m., in the kitchen, revealed one jar of Pimento Cheese in the refrigerator labeled, "...opened February 24, 2014...discard February 27, 2014..."

Interview with the Dietary Manager on March 3, 2014, at 9:15 a.m., in the kitchen, confirmed the Pimento Cheese was expired and was available for the residents.

Observation on March 4, 2014, at 2:00 p.m., in the dishwashing area of the kitchen, revealed one uncovered dirty food storage cart with dirty food trays stored on the cart. Further observation revealed the uncovered dirty food storage cart was stored in the same area where clean plates, clean cooking pans, and clean serving trays were

and Manager daily for two weeks with a completion date of 3/17/14. A 100% audit will then be completed weekly by Dietary Staff and manager during kitchen weekly audit indefinitely.

A Performance Improvement Plan was

sanitary storage of food items. The

Performance Improvement Plan was

reviewed during facility Performance

Improvement Meeting on 3/14/14 and attended by ED, DON, ADON, Medical

Director, Nursing Administration, and other

Department Managers. A 100% audit of all

food items in refrigerator, freezer, and dry

storage will be completed by Dietary Staff

initiated 3/3/14 to address procedures for

and not used.

Monitoring:

heet Page 5 of 9

3/3/14

DEPAR	CIMENT OF HEALTH	AND HUMAN SERVICES			rı	FORM): 03/10/2014 APPROVED	
STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES	7				0. 0938-0391	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		. 445314	B. WING			US	/05/2014	
NAME OF	PROVIDER OR SUPPLIER		<u>'-</u>	S	STREET ADDRESS, CITY, STATE, ZIP CODE	. 03	103/2014	
LIFE CA	RE CENTER OF MORE	RISTOWN		5	01 WEST ECONOMY ROAD			
		_		٨	MORRISTOWN, TN 37814			
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
			[Corrective Action:			
F 371	Continued From pag	ge 5	F3	71	On 3/4/14 dirty tray carts were immedia	ately	3/4/14	
	stored.	i			removed from area housing clean plate			
	Interview with the Dietary Manager on March 4, 2014, at 2.05 p.m., in the kitchen, revealed, "the food storage carts may be brought into the kitchen through the back door or through the dining room doorthere should be only one way the dirty food storage carts come into the kitchen" Further interview confirmed the uncovered dirty food cart was stored in the same area where clean plates, cooking pans, and serving trays are located and stored.				storage to dishwashing area of kitchen l	rea of kitchen by taff were lietary manager to		
					dietary staff. All dietary staff were			
				j	instructed on 3/4/14 by dietary manage			
				i	not receive dirty carts and trays from cla			
				ļ	-	can		
				ĺ	plate storage area of kitchen.		li	
				l	Residents with Potential to be Affected:		ļ <u>[</u>	
							[
					All residents have the potential to be	-		
F 441	483 65 INEECTION	CONTROL, PREVENT		ļ	affected.		<u> </u>	
. 3411	SPREAD, LINENS	CONTROL, PREVENT		i			' <u> </u>	
00 15	- · · · · · · · · · · · · · · · · · · ·	Ì	7° A.		Systematic Change:		3/14/14	
	The facility must esta	ablish and maintain an	-	ı	All dietary staff were in serviced on 3/12	/14	1	
į	Infection Control Pro-	gram designed to provide a		-	by Dietary manager on procedure for		i i	
j	safe, sanitary and co	mfortable environment and		- 1	receiving dirty tray carts. Dirty tray carts	will		
	to help prevent the development and transmission of disease and infection.			}	only be received through main dining ro	om	·	
				-	door into dishwashing side of kitchen. Al	t i		
	(a) Infection Control F	Infection Control Program]	staff will be in serviced by Staff	ĺ		
j	The facility must establish an Infection Control				Development Coordinator on 3/14/14 or	1		
-	Program under which	r which it -		1	procedure for taking dirty tray carts to		1	
	(1) Investigates, contr	rols, and prevents infections		- 1	dietary through dining room entrance.			
	in the facility; (2) Decides what prod				,			
	(2) Decides what procedures, such as isolation, should be applied to an individual resident; and			Ň	Monitoring:	.	3/13/14	
	(3) Maintains a record	of incidents and corrective			erformance Improvement plan was			
<u> </u>	actions related to infe	ctions.			nitiated on 3/13/14 to address procedure	,		
					or dirty tray carts being brought to Dieta			
! ((b) Preventing Spread	of Infection			daily audit will be conducted by Dietary			
	1) When the Infection	O Control Program			•			
		ident needs isolation to infection, the facility must	Manager to ensure procedure for dirty tray carts is followed for one month with a					
i	solate the resident.	ancodon, the facility must						
		rohibit employees with a			ompletion date of 4/3/14, then the audit	1	•]	
Ċ	communicable disease or infected skin lesions			W	vill be completed randomly and as neede	eeded.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/10/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

TATEMENT OF DEFICIENCIES (X1) PROVIDE IDENTIFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
		445314	B. WING			03/05/2014	
	PROVIDER OR SUPPLIER RE CENTER OF MOR	RISTOWN		50	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST ECONOMY ROAD IORRISTOWN, TN 37814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	from direct contact direct contact will the (3) The facility must hands after each di hand washing is incorprofessional praction (c) Linens Personnel must har transport linens so a infection. This REQUIREMENT by: Based on observat and interview, the fathygiene during incorprofession (#23) of twenty-nines. The findings includes Resident #23 was and December 31, 2012 Hypertension, Deme Chronic Obstructive Pressure Ulcer. Review of the Quart January 10, 2014, reurinary catheter and assistance with all and Observation of incorporation of incorporation of the county at 2:45 p.m., incorporation of the county and assistance with all and Observation of incorporation	with residents or their food, if ansmit the disease. It require staff to wash their rect resident contact for which dicated by accepted ite. Indicated ite process and ite. Indicated ite perform hand ite. Indicated ite perform hand ite. Indicated ite perform hand ite. Indicated	F	141	Corrective Action: Review and Education provided to LPN #2 regarding infection control policies and procedures by DON on 3/14/14. Residents with Potential to be Affected: All residents have the potential to be affected. Systematic Changes: Review and Education provided to all licensed nursing personnel regarding infection control policies and procedures to Staff Development Coordinator on 3/14/1. Monitoring: A Performance Improvement Plan was initiated on 3/5/14 to address infection control concerns with hands not being washed and gloves not changed before touching a clean item during resident care. The Performance Improvement Plan was reviewed during the facility Performance Improvement Plan was reviewed during the facility Performance Improvement Meeting on 3/14/14 with El DON, ADON, Medical Director, Nursing Administration, and other Department Managers. A audit is being completed dair for two weeks by DON, ADON, and other Nursing Administration to observe staff during residents care to ensure infection control policies and procedures are being followed with a completion date of 3/19/14. An Audit will then be completed	3/5/14 O,	
}	revealed Licensed Practical Nurse (LPN) #2 donned gloves and wiped large amounts of loose feces from the resident's gluteal area using				by DON, ADON, and other Nursing Administration weekly of random staff		

		AND HUMAN SERVICES				FORM.	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
	,	445314	B. WING	·		03/05/2014	
	IFE CARE CENTER OF MORRISTOWN			5	TREET ADDRESS, CITY, STATE, ZIP CODE 01 WEST ECONOMY ROAD MORRISTOWN, TN 37814		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 502 SS=D	revealed LPN #2 op resident's bed side supplies, without re washing the hands, additional feces from and perineum. Review of the facility May 1, 2012, reveating or contaminate blood or other body Interview with LPN: p.m., at the nursing failed to remove the hands prior to open table, and failed to furing the procedur 483.75(j)(1) ADMIN The facility must proservices to meet the facility is responsible of the services. This REQUIREMENT by: Based on medical resident the facility failed to expect the facility fa	Continued observation bened the drawer of the table and obtained additional moval of the soiled gloves or and resumed wiping in the resident's gluteal area by policy Hand Hygiene revised led, "when hands are visibly edor are visibly soiled with fluidswash hands" #2 on March 4, 2014, at 3:40 station, confirmed the LPN e soiled gloves or wash the ing the resident's bedside follow the hand hygiene policy e. ISTRATION Evide or obtain laboratory eneeds of its residents. The efor the quality and timeliness efor the quality and timeliness eroord review and interview, ensure laboratory tests were for one resident (#42) out of its reviewed.		502	member during resident care to ensur infection control policies and procedurare followed for six weeks with a completion date of 4/24/14. Corrective Action: For resident #42 physician was immediated by the DON on 3/4/14. The lab drawn on 3/4/14 for Hepatic function physician orders with no concern note physician. The Lipids and TSH lab was a per physician order on 3/5/14 due to finecessary, with no concerns noted per physician with results.	iately o was per d per drawn asting	3/4/14
	The findings include						
		dmitted to the facility on					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			•	FORM	APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES					C	OMB NO. 0938-039	
	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445314		1, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER			B. WING		 -	03.	/05/2014
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LIFE CARE CENTER OF MORRISTOWN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL					01 WEST ECONOMY ROAD MORRISTOWN, TN 37814		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	DΒE	(XS) COMPLETION DATE
	Muscle Weakness, Disorder, Depressiv Unspecified Psycho Hydrocephalus, Ost Traumatic Brain Syr Vein Thrombosis. Review of the Physi orders dated March orders for Lipids and Hormone blood test the thyroid gland is 1 months (October/Jaorigin date of April 2 Hepatic Function Pa (October/January/Apof June 9, 2011. Medical record revieresults for the Lipids Panels for the month 2014. Interview with the Dia 2014, at 10:45 a.m., station, confirmed the	with diagnoses including Explosive Personality e Disorder, Anxiety,	F5	502		fany and labs d labs and fany with that of labs s are nce th ED, s at o be macy nd	3/12/14